

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005519

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 71

FILED MAR 4 1963

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>Life</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Mem. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		d. STREET ADDRESS (If outside, give location) <u>105 Hockaday Ave.</u>	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary B Hockaday</u>			4. DATE OF DEATH Month Day Year <u>Feb. 26, 1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1875</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Callaway Co., Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Charles Bailey</u>		13b. MOTHER'S MAIDEN NAME <u>Zenie Martin</u>		14. NAME OF HUSBAND OR WIFE <u>Augustus Hockaday</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT Address <u>Mrs. Frank Baker, Fulton, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>same days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>chr. myocarditis, arteriosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Fulton, Mo.</u>	COUNTY <u>Callaway</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>1959</u> to <u>2/26/63</u> and last saw her alive on <u>2/26/63</u> Death occurred at <u>10:10 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Henry D. [redacted]</u> (Degree or title)	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>2/28/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-28-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton, Missouri</u>
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24. FUNERAL DIRECTOR <u>Monahan Funeral Home, Fulton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>March 2-1963</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

VS 300
Rev. 4/59
1 0147
2 0147
3
4 1
5 2
6
7 0
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9522X
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12 1-0
13 1-0

APR 3 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas M. Emmord

Licensed Embalmer No. 2064

P. O. Address Fulton, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.